

- ☐ Initiate CMH Program services
- ☐ Service Modification
- ☐ Add a service
- ☐ Increasing level/hours of service
- ☐ Decreasing level/hours of service
- ☐ Change of Provider (requires 2 ISARs)
- ☐ End a service

## CMH Program Transition Coordination Services Individual Service Authorization Request

Provider Name \_\_\_\_\_

Provider Number \_\_\_\_\_

Name: \_\_\_\_\_

Last,

First

MI

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Anticipated Discharge date  
from PRTF: \_\_\_\_\_

Case Management Provider: \_\_\_\_\_

(if known)

\_\_\_\_\_  
Name of Agency

\_\_\_\_\_  
Name of Case Manager

SERVICE TO BE PROVIDED

UNITS NEEDED

DMAS USE ONLY

Transition Coordination Services – H2015

1 Unit = 15 minutes (cannot exceed 160 units)

Reason for the request: \_\_\_\_\_

Check the allowable activities that are included in the client's plan. Indicate the approximate total number of units.

**Transition Coordination Activities:**

- ☐ assessment of the individual/family
- ☐ assistance with meeting CMH Program requirements for enrollment
- ☐ liaison between PRTF/Family/Individual/Providers/CM
- ☐ assistance with redetermination of Medicaid eligibility
- ☐ developing CSP
- ☐ identifying community service providers
- ☐ monitoring the initial transition to the community from PRTF

**Units needed**

Comments: \_\_\_\_\_

*I agree that the above plan of services is appropriate to the identified needs of this client. This service plan has been approved by the client and family/caregiver, as appropriate, and included in the CSP maintained in the transition coordination record.*

Transition Coordinator (print) \_\_\_\_\_

Signature \_\_\_\_\_

Phone No. \_\_\_\_\_

Fax No. \_\_\_\_\_

Date \_\_\_\_\_